## B. HEALTHCARE FOR WORKERS WITH DISABILITIES (HWD) PROGRAM

**Purpose:** This section implements the **Healthcare for Workers with Disabilities (HWD)** program. This program recognizes the employment potential of people with disabilities, and represents Washington State's response to the landmark "Ticket to Work" legislation passed by Congress in 1999. The enactment of the federal **Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999** enables people with disabilities to no longer have to choose between taking a job and having health care.

Under HWD, people with disabilities will be able to earn and save more money and purchase healthcare coverage for an amount based on a sliding income scale. HWD does not have an asset test. Since it is a categorically needy (CN) program, it also provides Medicaid Personal Care services (MPC) for those approved to receive them.

**NOTE:** Because this population is disabled by definition, it is very important that necessary supplemental accommodation policies and procedures are followed at all times. See NSA (Necessary Supplemental Accommodation) containing chapter 388-472-WAC.

Effective January 10, 2002

**WAC 388-475-1000 Healthcare for workers with disabilities (HWD) - Program description.**

This section describes the healthcare for workers with disabilities (HWD) program.

(1) The HWD program provides categorically needy (CN) Medicaid services as described in WAC 388-529-0200.

(2) The department approves HWD coverage for twelve months effective the first of the month in which a person applies and meets program requirements. See WAC 388-475-1100 for "retroactive" coverage for months before the month of application.

(3) A person who is eligible for another Medicaid program may choose not to participate in the HWD program.

(4) A person is not eligible for HWD coverage for a month in which the person received Medicaid benefits under the medically needy (MN) program.

(5) The HWD program does not provide long-term care (LTC) services described in chapter 388-513 and 388-515 WAC. LTC services include institutional.

waivered, and hospice services. To receive LTC services, a person must qualify and participate in the cost of care according to the rules of those programs.

Effective January 10, 2002

**WAC 388-475-1050 Healthcare for workers with disabilities (HWD) - Program requirements.**

This section describes requirements a person must meet to be eligible for the healthcare for workers with disabilities (HWD) program.

(1) To qualify for the HWD program, a person must:

(a) Meet the general requirements for a medical program described in WAC 388-503-0505(3)(a) through (f);

(b) Be age sixteen through sixty-four;

(c) Meet the federal disability requirements described in WAC 388-475-1150;

(d) Have net income at or below two hundred twenty percent of the federal poverty level (FPL) (see WAC 388-478-0075 for FPL amounts for medical programs); and

(e) Be employed full or part time (including self-employment) as described in WAC 388-475-1200.

(2) To determine net income, the department applies the following rules to total gross household income in this order:

(a) Deduct income exclusions described in WAC 388-450-0020; and

(b) Follow the CN income rules described in:

(i) WAC 388-450-0005(3) and (4), Income--Ownership and availability;

(ii) WAC 388-450-0085, Self-employment income—Allowable Expenses;

(iii) WAC 388-450-0150(1), (2), (3), and (5), SSI-related income allocation;

(iv) WAC 388-450-0210(4)(b), (e), and (h), Countable income for

medical programs;

(v) WAC 388-506-0620, SSI-related medical clients; and

(vi) WAC 388-511-1130, SSI-related income availability.

(3) The HWD program does not require an asset test.

(4) Once approved for HWD coverage, a person must pay his/her monthly premium in the following manner to continue to qualify for the program:

(a) The department calculates the premium for HWD coverage according to WAC 388-475-1250;

(b) If a person does not pay four consecutive monthly premiums, the person is not eligible for HWD coverage for the next four months and must pay all premium amounts owed before HWD coverage can be approved again; and

(c) Once approved for HWD coverage, a person who experiences a job loss can choose to continue HWD coverage through the original twelve months of eligibility, if the following requirements are met:

(i) The job loss results from an involuntary dismissal or health crisis; and

(ii) The person continues to pay the monthly premium.

Effective January 10, 2002

**WAC 388-475-1100 Healthcare for workers with disabilities (HWD) - Retroactive coverage.**

This section describes requirements for retroactive coverage provided under the healthcare for workers with disabilities (HWD) program.

(1) Retroactive coverage refers to the period of up to three months before the month in which a person applies for the HWD program. The department cannot approve HWD coverage for a month that precedes January 1, 2002.

(2) To qualify for retroactive coverage under the HWD program, a person must first:

(a) Meet all program requirements described in WAC 388-475-1050 for each month of the retroactive period; and

(b) Pay the premium amount for each month requested within one hundred twenty days of being billed for such coverage.

(3) If a person does not pay premiums in full as described in subsection (2)(b) for all months requested in the retroactive period, the department denies retroactive coverage and refunds any payment received for those months.

## CLARIFYING INFORMATION

### HWD Eligibility

Some people who are not eligible for other medical programs because of excess resources may be eligible for HWD, which has no asset test. Such people would include:

1. A person with income above or below the CN income level CNIL / MN income level (MNIL) with resources above the limit for S02, S95, or S99; or

2. A person not eligible for medical assistance under the C, G, or L Series coverage groups because of excess resources. Such a person may be eligible for Medicaid Personal Care services under HWD, but not eligible for LTC services under HWD.

### Program Choice – HWD Or Other Medical Programs

The HWD program is not the program of highest priority for all persons who meet program requirements. Since HWD always requires a premium payment, the program of highest priority for a person who is eligible for both HWD and another CN program is the one that has a smaller or no premium requirement. For example:

1. A child is first considered for the CN children's program (F06) or SCHIP (F07).

2. A pregnant woman is first considered for the CN pregnancy program (P02).

3. A disabled child adult (DAC) is first considered for the CN disability program (S02).

## Program Choice – HWD or MN

Some people who are eligible for the HWD program may prefer to receive Medicaid under the MN program. They do not have to participate in HWD, unless they choose to do so. The HWD Award Letter will provide those approved for the program with a comparison of what their spenddown amount would be under the MN program.

For most people, HWD is the preferred program because:

1. CN provides more extensive coverage than MN; and

2. The HWD premium is most likely less than the monthly spenddown amount.

A person who is approved for MN (in active status) cannot be opened for HWD CN coverage until the first of the month after MN coverage can be closed. In certain situations, it may be to the client's advantage to continue the current MN certification.

### EXAMPLE 1

With medical expenses incurred in December and January, a client meets the spenddown requirement of $948 on January 10 for the base period of December, January, and February. The department approves MN coverage effective January 10. (The HWD program began in January). The client contacts staff with the thought of switching to the HWD program, although his medical needs for February do not require the additional services provided under the CN scope of care. Since the client is now open on MN and the department cannot approve HWD coverage until February, it would not be to the client's advantage to switch to the HWD program until March.

Health insurance premiums are not a deductible expense for the HWD program when determining eligibility or the amount of monthly premiums. Health insurance premiums are a deductible expense, however, when determining a person's spenddown liability for the MN program. For this reason, a person may prefer MN instead of HWD coverage.

### EXAMPLE 2

A person that meets all HWD requirements has a health insurance premium that reduces countable income to below the MN standard. This person, who would have no spenddown, may choose the MN program that provides less comprehensive coverage but does not require a premium payment.

## SSI Clients - CN

People with disabilities who work and remain eligible for SSI remain eligible for CN Medicaid because of the status provided them under 1619(a) and 1619(b) provisions of the Social Security Act. They are eligible for CN Medicaid as a member of the S01 coverage group and do not participate in the HWD program.

The HWD program provides people eligible for SSI an incentive to begin earning money in excess of the 1619(b) threshold amount. Although earnings above the threshold may change their eligibility for SSI, they can continue their Medicaid coverage by enrolling in the HWD program, if they meet other program requirements.

For clients who want HWD, staff must screen for S08 instead of S02 when entering client information into ACES. Otherwise, ACES will look at CN (S02) first, then S95 and S99, if appropriate. S02 will not trickle to S08. If an SSI-related client has income below the CNIL and resources above the CN / MN standard, the client can be considered for the HWD program if they meet other program requirements. If an SSI-related client has income that exceeds the CNIL and has resources at or below the CN/MN standard, the client can be considered for the HWD or MN program.

## Premiums and Spenddown

HWD premiums and incurred medical expenses used to reduce a person's spenddown should not be confused with one another when determining eligibility for Medicaid.

1. Medical expenses used to reduce spenddown are not used to reduce an HWD premium

2. Premiums owed by a person whose HWD coverage has ended because of non-payment cannot be used to reduce spenddown for the MN program. Only incurred medical expenses or health insurance premiums actually paid can be used to reduce a person's spenddown amount.

- See CITIZENSHIP/ALIEN STATUS, RESIDENCY, and SSN to determine whether a client meets the general eligibility requirements.

- See WAC 388-475-1150 to determine whether the client meets the disability requirement.

- See WAC 388-475-1200 to determine whether the client meets the employment requirement.

- See WAC 388-475-1250 for requirements regarding the payment of premiums for HWD coverage.

## WORKER RESPONSIBILITIES

### HWD Website

The **HWD Website** was developed by the Finance Division and the Medical Assistance Administration (MAA) to determine eligibility and premium amounts. It can also be used as a trial eligibility calculator and to provide a spenddown comparison amount. Staff can use the spenddown amount to discuss a client's program options.

When discussing the option of choosing HWD with a client living in an ALF, staff should estimate the comparison amount of non-institutional Medicaid in an ALF to be non-excluded income above the MNIL. The client keeps the personal needs allowance described in WAC 388-478-0045 and pays what remains of the MNIL to the facility for room and board. See **NON-INSTITUTIONALIZED** in **Long-Term Care.**

### Local Office Staff Responsibilities

1. If a client who is applying for or receiving other benefits expresses interest in the HWD program:

    a. Determine whether the client appears to meet program requirements, which include:

        (1) Being age 16 through 64;

        (2) Have at least a self-reported disability; and

        (3) Have earned income; and

    b. Forward client information to designated staff, if the client:

        (1) Appears to meet program requirements and wants to apply for HWD; or

        (2) Does not appear to meet program requirements, but still wants to apply after you have explained to them they do not appear to meet program requirements.

2. Local staff who want to use the **HWD Website** (see below) for determining income eligibility and the premium can do so, if this will facilitate discussing program options with a client.

   **NOTE:** Depending upon individual circumstances, the client's program options may include HWD, MN at home, or CN/MN non-institutional Medicaid in an alternate living facility (ALF).

   **NOTE:** Clients living in an ALF who enroll in HWD continue to pay room and board, which is not a service covered by Medicaid programs. The room and board amount is not deducted when determining eligibility or calculating the HWD premium amount.

3. The **HWD Website** can be used as a trial eligibility calculator by clicking on the **Entry Form** tab to begin the process. Only designated staff "Log In" and save entries. See **HWD Website** and **Central Processing – Designated Staff Responsibilities 1.** below for information on using the website.

   **NOTE:** If you use the **HWD Website** to discuss a client's program options before sending information to designated staff, document your discussion with the client in the ACES narrative.

   Explain to the client that only designated staff make the final determination of eligibility and the HWD premium amount.

4. For a client applying for HWD who is applying for or receiving other benefits, route or fax a copy of the application (or the DSHS 14-078 Eligibility Review Form) to designated staff.

   **NOTE:** Designated CSD staff have ACES Super User status and do not determine or maintain eligibility for other program benefits.

   Designated HCS Staff coordinate eligibility for other programs with the HCS worker of record in their region.

5. For a client applying for HWD who is not applying for or receiving other benefits, route the case record to designated staff.

6. When routing HWD applications or case records, the following contact information applies:

a. **CSD** – Send to HWD Unit in the Region 1 Okanogan CSO (024); Phone: 1-866-272-7630; Fax: 509-826-7293.

b. **HCS** – Send to the designated staff in your region. The regional information phone numbers are:

| | |
|---|---|
| Region 11: 1-800-459-0421 | Region 14: 1-800-346-9257 |
| Region 12: 1-800-822-2097 | Region 15: 1-800-442-5129 |
| Region 13: 1-866-608-0836 | Region 16: 1-800-462-4957 |

**For HCS Staff only:**

For a client who is employed, not eligible for LTC or non-institutional Medicaid in an ALF as described in WAC 388-513-1305, and wants to apply for HWD:

1. Deny the application for LTC or non-institutional Medicaid; and

2. Transfer the case to designated HCS staff to determine HWD eligibility.

**Central Processing – Designated Staff Responsibilities**

1. Use the **HWD Website** to determine eligibility and premium amounts.

   a. When determining income to enter into the HWD Website, apply SSI-related income exclusions described in WAC 388-450-0020 (3) through (7) and (9) through (26).

   b. For spouses living together or separately after placement into an ALF described in WAC 388-513-1305(1), see WAC 388-506-0620(5).

**NOTE:**

- The **HWD Website** does not apply rules regarding excluded income or the separation of income in the month after the month of separation for spouses living in an ALF.

- For the determination of HWD eligibility, the **HWD Website** applies SSI-related income disregards and deeming rules for the CN program. For the determination of the spenddown comparison amount, it applies SSI-related income disregards and deeming rules for the MN program.

- For the determination of HWD premiums, the **HWD Website** uses income entered to determine eligibility and applies rules described in WAC 388-475-1250(1) and (3).

2. Enter the HWD enrollee as the AU head of household (HOH). The HOH will cross over to OFR as the client to be billed for HWD coverage.

3. For entering information into ACES for retroactive coverage under HWD, see WORKER RESPONSIBILITIES– Retroactive Coverage under WAC 388-475-1250.

4. Enter the correct AREP type in ACES to send the medical assistance ID card to the AREP.

**NOTE:** Since the AREP does not cross over to OFR during the ACES interface, the HWD billing statement is not sent to the AREP. Although the client is responsible for making sure HWD premiums are paid, be sure to send a copy of all letters to the client's authorized representative when using Word documents to notify the client of program eligibility, etc., including those that indicate the premium amount

**NOTE:** Payments received will be reflected on the following month's billing statement. The department does not issue another kind of receipt for payment of HWD premiums received, unless the person makes them in person at OFR. Payment by mail is the preferred method of making HWD premium payments.

5. Document results obtained from the HWD Website in ACES for those who choose HWD:

   a. For eligible clients, follow ACES procedures to screen for the S08 program. On the SPEC screen enter a “Y” in the eligibility field and the premium amount. See WORKER RESPONSIBILITIES Initial Premium Amount under WAC 388-475-1250 for entering the initial premium amount. ACES will open HWD coverage for twelve months.

**NOTE:** Members of an American Indian / Alaska Native (AI/AN) population are exempt from HWD premiums. Until WAC 388-475-1250 is amended to reflect the AI/AN exemption, follow normal procedures to obtain an ETR approval before opening benefits and entering the exemption in ACES.

**NOTE:** When determining eligibility for members of an AI/AN population, do not finalize the premium calculation on the HWD Website. On the SPEC screen enter a "Y" in the eligibility field and a "0" for the premium amount.

b. For ineligible clients, follow ACES procedures to screen for the S08 program. On the STAT screen enter a 599 reason code in the AU Status field.

6. Follow ACES procedures to screen for S03 and S05 when the client is entitled to Medicare.

a. For those approved for HWD that have income or resources that exceed S03 or S05 standards, notify the MAA Buy-In Unit that the department needs to pick up payment of the client's Part B premium.

**NOTE:** The department is required to pay the Part B premium for all Medicaid clients not eligible for S03 or S05 and uses state funds to do so.

b. When notifying the MAA Buy-In Unit, use the following contact information to send the client's ACES CLID and HWD effective date:

| | | |
|---|---|---|
| Audrey Finnigan | finniaa@dshs.wa.gov | phone (360) 725-1894 |
| Terry Popp | popptv@dshs.wa.gov | phone (360) 725-1221. |

**NOTE:**

- Enrollment in the HWD program is **optional.** In some instances it may be to a client's advantage to choose the MN program instead, e.g., a person who is eligible for MN that has unpaid medical expenses to meet spenddown and does not need additional services provided under the CN program.

- A person approved for MN (in Active status) cannot be opened for HWD CN coverage until the first of the month after MN coverage is closed.

- When denying MPC or LTC Services under regular CN rules, look at HWD as an option for MPC Services if the client is employed.

7. For a client approved for HWD who wants to switch to MN (or CN or MN in an ALF), do the following:

a. If the change can be made before the ACES deadline, close HWD at the end of that month and open the other program for the first of the following month.

**EXAMPLE**

HWD client calls on June 15 to request her medical coverage be changed to MN. She must enter the hospital for surgery next month and will not be able to work for several months. The hospital bill will meet her spenddown liability. HWD coverage is closed effective June 30 and a pending MN case is screened for the base period beginning July 1.

b. If the change cannot be made before the ACES deadline, close HWD at the end of the next month and open the other program for the first of the following month.

**EXAMPLE**

HWD client calls on June 25 to request her medical coverage be changed to MN. She must enter the hospital for surgery later next month and will not be able to work for several months. Because of the admission date and the nature of the procedure, she may remain in the hospital for a few days in the following month of August. HWD coverage is closed effective July 31 and a pending MN case is screened for the base period beginning August 1. The HWD premium for July for which she will be billed in August will remain her responsibility and is used to reduce any spenddown amount for the base period beginning in August.8.

Send letters to the client, using Word documents made available to designated staff and adding free form text when appropriate. Be sure to send a copy of all letters to a client's authorized representative.

8. Document approval or denial as well as any letters sent on the ACES narrative page.

9. When denying an application or review, follow ACES procedures to determine eligibility for other medical programs. HWD is subject to redetermination rules described in Chapter 388-434 WAC.

Effective January 10, 2002

**WAC 388-475-1150 Healthcare for workers with disabilities (HWD) - Disability requirements.**

This section describes the disability requirements for the two groups of individuals that may qualify for the healthcare for workers with disabilities (HWD) program.

(1) To qualify for the HWD program, a person must meet the requirements of the Social Security Act in section 1902 (a) (10) (A) (ii):

(a) (XV) for the basic coverage group (BCG); or

(b) (XVI) for the medical improvement group (MIG).

(2) The BCG consists of individuals who:

(a) Meet federal disability requirements for the Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) program; or

(b) Are determined by the division of disability determination services (DDDS) to meet federal disability requirements for the HWD program.

(3) The MIG consists of individuals who:

(a) Were previously eligible and approved for the HWD program as a member of the BCG; and

(b) Are determined by DDDS to have a medically improved disability. The term "medically improved disability" refers to the particular status granted to persons described in subsection (1) (b).

(4) When completing a disability determination for the HWD program, DDDS will not deny disability status because of employment.

## CLARIFYING INFORMATION

### Disability Determination – Medicaid Eligibility under HWD

In Washington State, the Social Security Administration contracts with the Division of Disability Determination Services (DDDS) to determine whether a person currently meets federal disability requirements for program services.

HWD introduces a different level of disability for Medicaid eligibility because of the Medical Improvement Group (MIG) established under Section 1902 (a) (10) (A) (ii) (XVI) of the Social Security Act. As it currently does for those who apply for federal disability benefits, DDDS also will determine whether a person previously eligible for such benefits has a severe "medically determinable impairment" (SMDI).

Under the section of the Act described above a person with a medically improved disability must have an SMDI and meet the employment requirements described in WAC 388-475-1100 to continue eligibility for HWD as a member of the Medical Improvement Group.

**NOTE:** To continue to be eligible for HWD as a member of the Medical Improvement Group, a person must have been eligible and approved for the program as a member of the Basic Coverage Group.

### HWD Referral to DDDS

HWD introduces a change in the disability determination process. When determining disability for Medicaid under the HWD program, DDDS will not look at the person's earnings. This differs from the process DDDS uses when determining disability for SSI or SSDI cash benefits.

## WORKER RESPONSIBILITIES

### Local Office Staff Responsibilities

1. For a client whose application for HWD is being routed to designated staff, follow local procedures to initiate a disability determination if the client is not already approved for disability benefits. Contact the client to gather medical information currently available and obtain signed release of information forms for the referral packet.

2. For a client referred to the local office by designated HWD staff for a disability determination, follow local procedures to initiate a disability determination.

3. According to local procedures, contact the person to gather medical information currently available and obtain signed release of information forms for the referral packet.

4. Use the DSHS 14-084(X) Financial/Social Service Communication Form or (local form) and follow procedures described in SSI-Related Adult Medical to complete the DDDS referral. Indicate on the referral form used that the client is applying for the HWD program.

5. If the client has a pending application for federal disability benefits that did not indicate the client is applying for HWD coverage, complete a referral to DDDS to provide this additional information. DDDS does not look at the amount of a person's earned income when determining disability status for HWD.

6. If designated staff indicate the client no longer meets the disability requirement for the Basic Coverage Group (BCG), indicate in the DDDS referral that the client needs a disability determination for the Medically Improved Group (MIG).

7. Take immediate action to forward the DSHS 14-144(X) Medicaid Disability Decision received from DDDS to designated staff completing the HWD application or review.

**Central Processing - Designated Staff Responsibilities**

1. For a client not currently approved for disability benefits:

   a. Include free form text in the letter for pending the application, which tells the client to contact the local office within ten days to initiate the DDDS referral process;

   b. Route or fax a copy of the application (or the DSHS 14-078 Eligibility Review Form) and the pending letter to the local office; and

   c. Attach a cover memo or routing slip that explains the client's need for assistance in completing the disability determination process.

**EXAMPLE (of text for referral):**

Non-Grant Medical Assistance Determination (NGMA) for HWD
Attached is HWD application (or Eligibility Review)
Designated staff contact is (staff member's name) at (phone number and email)
Route decision to (staff member's name) at MS (number)

2. For a client that has a pending application for federal disability benefits, which did not indicate the client is applying for HWD coverage, advise staff in the local

office to complete a referral to DDDS to provide this additional information. DDDS does not look at the amount of a person's earned income when determining disability status for HWD.

3. Request retroactive approval if the client had a medical need in any of the three months before the month of application.

4. Pend the application until a decision is received from DDDS. Inform the client that a determination may take up to up to 60 days. Do not consider eligibility for MI while waiting for a decision. Document in ACES the reason for delays beyond 60 days from the date of application, e.g., no response yet from DDDS.

5. Use the BarCode system to identify local office staff working with the client to complete the DDDS process.

6. For a person receiving HWD benefits that no longer meets the disability requirement for the BCG, follow procedures described above when routing a referral to the local office. Use free form text to advise the client and local staff that DDDS needs to complete a disability determination for the Medically Improved Group (MIG).

7. Continue HWD coverage until you receive a decision from DDDS as to whether the client meets the disability requirement for the MIG.

8. To approve HWD coverage for a member of the MIG, use the new “Disability Source” code (CD) to indicate the client has a medically improved disability as determined by DDDS.

9. For a client receiving HWD benefits that no longer meets the disability requirements for BCG or MIG, continue HWD coverage until you redetermine eligibility for other medical programs. HWD is subject to redetermination rules described in Chapter 388-434 WAC.

10. Send letters to the client, using Word documents made available to designated staff and adding free form text when appropriate. Be sure to send a copy of all letters to a client's authorized representative.

11. Document approval or denial as well as any letters sent on the ACES narrative page.

Effective January 10, 2002

**WAC 388-475-1200 Healthcare for workers with disabilities (HWD) - Employment requirements**.

This section describes the employment requirements for the basic coverage group (BCG) and the medical improvement group (MIG) for the healthcare for workers with disabilities (HWD) program.

(1) For the purpose of the HWD program, employment means a person:

(a) Gets paid for working;

(b) Has earnings that are subject to federal income tax; and

(c) Has payroll taxes taken out of earnings received, unless self-employed.

(2) To qualify for HWD coverage as a member of the BCG, a person must be employed full or part time.

(3) To qualify for HWD coverage as a member of the MIG, a person must be:

(a) Working at least forty hours per month; and

(b) Earning at least the local minimum wage as described under section 6 of the Fair Labor Standards Act (29 U.S.C. 206).

## CLARIFYING INFORMATION

### Employment – Basic Coverage Group (BCG)

HWD coverage under the BCG does not require that a person be working a minimum number of hours or be receiving a minimum level of earnings. However, people who want to enroll in the HWD program must provide evidence they have earned income, i.e., they are working as described in the program requirements.

To satisfy the program requirement of being employed, a person must provide evidence that FICA and payroll taxes are taken out of their earnings. People who are self-employed must provide a copy of their IRS Schedule SE and show evidence of self-employment earnings with entries for net earning or loss on the IRS Form 1040, Schedule C or Schedule F. If the self-employed person has not been in business long enough to file a tax return, business records or a copy of the business license can

provide sufficient evidence of employment if the federal tax return is made available when completed and filed.

**Employment – Medical Improvement Group (MIG)**

HWD coverage under the MIG does require that a person be working a minimum number of hours and be receiving a minimum level of earnings. In addition to providing evidence of their employment, people who have a medically improved disability and want to continue their HWD coverage must be working at least 40 hours per month and be earning at least minimum wage.

People with a medically improved disability who are self-employed must provide the same evidence required for members of the BCG.

## WORKER RESPONSIBILITIES

1. Use documents obtained from the client for determining income to verify employment status, if the documents indicate tax withholdings, e.g., Social Security and Medicare.

2. Do not use a personal check or pay stub that does not indicate tax withholdings as evidence of earnings gained through employment for HWD eligibility requirements.

3. Contact the client's employer when necessary to verify tax withholdings.

4. For clients who are self-employed, but have not been in business long enough to file a tax return, accept business documents, e.g., a copy of the business license, as evidence of self-employment. Advise them to maintain business records and require them to provide a copy of their federal tax return when it becomes available.

Effective January 10, 2002

**WAC 388-475-1250 Healthcare for workers with disabilities (HWD) - Premium payments.**

This section describes how the department calculates the premium amount a person must pay for healthcare for workers with disabilities (HWD) coverage. This section also describes program requirements regarding the billing and payment of HWD premiums.

(1) When determining the HWD premium amount, the department counts only the income of the person approved for the program. It does not count the income of another household member.

(2) When determining countable income used to calculate the HWD premium, the department applies the following rules:

(a) Income is considered available and owned when it is:

(i) Received; and

(ii) Can be used to meet the person's needs for food, clothing, and shelter, except as described in WAC 388-511-1130.

(b) Loans and certain other receipts are not considered to be income as described in 20 C.F.R. Sec. 416.1103, e.g., direct payment by anyone of a person's medical insurance premium or a tax refund on income taxes already paid.

(3) The HWD premium amount equals a total of the following (rounded down to the nearest whole dollar):

(a) Fifty percent of unearned income above the medically needy income level (MNIL) described in WAC 388-478-0070; plus

(b) Five percent of total unearned income; plus

(c) Two point five percent of earned income after first deducting sixty-five dollars.

(4) When determining the premium amount, the department will use the current income amount until a change in income is reported and processed.

(5) A change in the premium amount is effective the month after the change in income is reported and processed.

(6) For current and ongoing coverage, the department will bill for HWD premiums during the month following the month in which coverage is approved.

(7) For retroactive coverage, the department will bill the HWD premiums during the month following the month in which coverage is requested and necessary

information is received.

(8) If initial coverage for the HWD program is approved in a month that follows the month of application, the first monthly premium includes the costs for both the month of application and any following month(s).

(9) As described in WAC 388-475-1050(4)(b), the department will close HWD coverage after four consecutive months for which premiums are not paid in full.

(10) If a person makes only a partial payment toward the cost of HWD coverage for any one month, the person remains one full month behind in the payment schedule.

(11) The department first applies payment for current and ongoing coverage to any amount owed for such coverage in an earlier month. Then it applies payment to the current month and then to any unpaid amount for retroactive coverage.

## CLARIFYING INFORMATION

### Countable Income – Premium Amount

The "Ticket to Work" legislation gives states flexibility when determining the type and amount of cost sharing they require for enrollment in the HWD program with the following exception. States cannot require a premium amount that exceeds 7.5% of the enrollee's total income.

The standard income methodology used for SSI-related programs does not apply when determining countable income used to calculate HWD premiums. For the determination of HWD premiums, the HWD website uses income entered to determine eligibility and applies rules described in WAC 388-475-1250 (1) and (3).

Income used to calculate HWD premiums includes only that of the person enrolling in the program. If both spouses apply, their premiums are calculated separately using only the income of each spouse.

**NOTE:** Members of an American Indian / Alaska Native (AI/AN) population are exempt from HWD premiums. **NOTE:** Until WAC 388-475-1250 is amended to reflect the AI/AN exemption, follow normal procedures to obtain an ETR approval before opening benefits and entering the exemption in ACES. . When determining eligibility for members of an AI/AN population, do not finalize the premium calculation on the HWD

Website. On the SPEC screen enter a "Y" in the eligibility field and a "0" for the premium amount.

The **HWD Web** calculates the HWD premium using the program formula and then compares that amount to 7.5% of the enrollee's total income. The lesser of the two is indicated as the correct premium amount and transmitted to the Office of Financial Recovery (OFR). OFR uses information it receives from the HWD Web for data comparison, but uses the premium amount entered in the ACES SPEC screen for billing purposes.

**Premium Example:** A person earns $665 per month and receives $771 SSDI.

| **Income** | | |
|---|---|---|
| Monthly earned income | $665.00 | |
| Monthly unearned income (Social Security) | $771.00 | |
| Total monthly income | $1,436.00 | |
| | | |
| **Premium Calculation - first** | | |
| 1. Subtract the MNIL ($571) from **unearned** income ($771 - $571) | $200.00 | |
| Take 50% of the result (.5 x $200 = $100) | $100.00 | |
| Include the result as part of your premium | | **$100.00** |
| | | |
| 2. Calculate 5% of **unearned** income (.05 x $771 = $38.55) | $38.55 | |
| Include the result as part of your premium | | **$38.55** |
| | | |
| 3. Subtract $65 from gross **earned** income ($665 - $65 = $600) | $600.00 | |
| Take 2.5% of the result (.025 x $600 = $15) | $15.00 | |
| Include the result as part of your premium | | **$15.00** |
| | | |
| **PREMIUM AMOUNT (rounded down) - using formula** | | **$153.00** |
| **Premium Calculation - second** | | |
| Calculate 7.5% of total income (.075 x $1,436) | $107.70 | |
| | | |
| **PREMIUM AMOUNT (rounded down) - using percentage** | | **$107.00** |
| **ACTUAL PREMIUM (lesser of first and second calculations)** | | **$107.00** |

When calculating premiums, round down to the nearest whole dollar. In this example, the client pays $107 per month.

**Initial Premium**

If a person applies in one month for HWD coverage that is not approved until the next month, the first monthly premium will include costs for both the first and second month.

**EXAMPLE**

A client applies for HWD on July 10 and provides information needed to complete the application on August 6. HWD is approved on August 7 for coverage beginning July 1 and OFR receives the premium calculation from ACES via the interface on the last business day of August. The client receives a bill for the initial premium, which includes charges for both July and August for HWD coverage that begins July 1.

**NOTE:** In this example, if the client does not pay this bill in full by the end of September, the client will be one month behind in making premium payments.

### Changes in Premium

Changes in the HWD premium will take effect the first of the following month in which the change is reported and processed as a change in circumstances. For a person who experiences a job loss and chooses to continue HWD coverage as described in WAC 388-475-1050(4)(c), the premium will be based on unearned income only when earnings are no longer received.

## WORKER RESPONSIBILITIES

### Initial Premium Amount

1. When approving an application that includes months prior to the current month (back to the month of application), enter a total amount of premiums owed for each of these months and the current month as the first month's premium amount. Add free form text to itemize the amount for each month on the award letter, using Word documents made available to designated staff, and explain that the total amount is the first month's premium.

**NOTE:** The client is not required to pay a premium for each of the months back to the month of application in which no medical need occurred. Once it has been made clear for which months the client wants to purchase HWD coverage, the premium amount entered on the SPEC screen should reflect the number of months for which a medical assistance ID card will be issued.

2. Take immediate action to process any change in the client's premium amount after allowing for the 10-day advance notice requirement.

**NOTE:** Since the HWD premium amount is billed in the month following the month of coverage, the premium amount should reflect the income received during the month of coverage whenever possible. If not possible, due to time of reporting, advance notice or processing requirements, make the change effective the first of the next following month unless a different income amount can and should be applied for the next month of coverage.

3. Explain to client the importance of correctly identifying months in the retroactive period for which HWD coverage will be purchased. If the client does not pay in full the premium amount for each and every month requested, the retroactive coverage will be denied.

4. Explain to the client the importance of talking to providers from whom they have received services for which they have already paid during retroactive months. Providers are not required to reimburse clients for such payment when they later present a medical ID card.

**Retroactive Coverage**

1. For retroactive coverage, enter information in the HWD Website and screen for S08 coverage in ACES for retroactive months under a different AUID. Pend the application for retroactive coverage until notified by OFR (by email) whether the client has paid premiums for the months requested.

2. For a client that pays premiums for retroactive coverage, open the months of coverage historically in ACES and send a letter of approval, using Word documents made available to designated staff.

3. For a client that does not pay in full for retroactive coverage, enter a 599 reason code in ACES and send a letter of denial, using Word documents made available to designated staff. OFR is responsible for refunding any partial payments received for retroactive coverage.

**ACES – OFR Interface**

1. The interface between ACES and OFR will be used to communicate information regarding the payment of premiums. Take immediate action on either of the two alerts you may receive from OFR via the interface:

   a. The client has not paid premiums for four consecutive months; or

b. The client has not paid premiums for retroactive coverage.

2. When OFR notifies you via the interface that the client has not paid premiums for four consecutive months:

   a. Send notice to close HWD coverage;

   b. Enter the four-month sanction period in ACES; and

   c. Continue CN Medicaid until you can redetermine eligibility for other medical programs.

3. Send letters to the client, using Word documents made available to designated staff and adding free form text when appropriate. Be sure to send a copy of all letters to a client's authorized representative.

4. Document approval or denial as well as any letters sent on the ACES narrative page.

5. Contact Vicki Butler at OFR (butlevl@dshs.wa.gov) when a client applying for HWD had previous coverage closed for not paying premiums. OFR will not communicate to ACES via the interface whether premiums owed in the past have been paid.